Complete Summary

GUIDELINE TITLE

Screening for chlamydial infection: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for chlamydial infection. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):90-4. [7 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Chlamydia trachomatis infection

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses

Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To make recommendations for screening for chlamydial infection.
- To update the 1995 recommendations contained in the Guide to Clinical Preventive Services, second edition.

TARGET POPULATION

- All sexually active women aged 25 years and younger
- Asymptomatic pregnant women aged 25 years and younger
- Other asymptomatic women at increased risk for infection
- Asymptomatic men
- High-risk young men

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for chlamydial infection using endocervical or urethral swab specimens and urine specimens. Laboratory testing by culture, antigen detection tests (direct fluorescent antibody assay and enzyme immunoassay), non-amplified nucleic acid hybridization, or newer technologies based on amplified DNA assays (polymerase chain reaction, ligase chain reaction, strand displacement assay, hybrid capture system, and transcription-mediated amplification of RNA).

MAJOR OUTCOMES CONSIDERED

- Incidence of pelvic inflammatory disease
- Prevalence of chlamydial infection
- Pregnancy outcomes, including premature rupture of membranes, low birth weight, infant survival, and small-for-gestational age births

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The topic of chlamydia was searched in the MEDLINE, the HealthSTAR, and the Cochrane Library databases from January 1994 to November 1999; PubMed was searched for recent articles not yet indexed in MEDLINE. Cost studies were searched in the same databases from January 1989 to November 1999.

A single reader reviewed all English abstracts. Papers were selected for full review if they were about Chlamydia trachomatis genitourinary infections in men,

nonpregnant women, or pregnant women and were relevant to key questions in the analytic framework or if they were related to cost. Reviews, policy statements, and other papers with contextual value were also obtained from the searches. Studies published as abstracts were not included in the search, although pertinent abstracts may be referred to in the text but not included in evidence tables. Review of reference lists of other relevant papers identified additional studies. Experts in the field also supplied references. Papers published before 1994 were cited if important to the interpretation of more recent papers.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr;20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Health Sciences University Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

EPC staff assigned evidence codes and quality ratings to all studies based on criteria developed by the USPSTF. To demonstrate screening strategy outcomes, EPC staff developed a balance sheet comparing 3 populations including a low risk health maintenance organization (HMO) population utilizing a risk factor questionnaire and assumptions from a randomized, controlled trial of screening, a theoretical high-risk population, and a theoretical low-risk population not using a risk factor questionnaire.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

COST ANALYSIS

Evaluation of cost-effectiveness of a specific screening strategy considers test performance, cost, treatment and disease outcomes, prevalence of infection in the screened population, and other factors. The U.S. Preventive Services Task Force (USPSTF) identified 8 cost-effectiveness or cost-benefit analyses that examined screening in non-pregnant and pregnant women. These analyses suggest that screening may be cost-saving when conducted among nonpregnant women who are at moderate to high risk of chlamydial infection. These studies also suggest that selective screening is more likely to be cost-effective than universal screening, and that less expensive and more sensitive DNA or RNA tests would improve cost-effectiveness when compared with culture. However, due to inconsistencies in methodology and assumptions made in these cost analyses, the USPSTF concludes that available evidence on cost-effectiveness is insufficient to guide specific screening recommendations. An interactive model that allows clinicians to compare the cost-effectiveness of different screening strategies is available at www.cdc.gov/nchstp/dstd/HEDIS.htm.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review . Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about

the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations for screening for Chlamydia infection from the following groups were discussed: the Canadian Task Force on Preventive Health Care, the Centers for Disease Control and Prevention, and the American College of Obstetricians and Gynecologists.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

- The US Preventive Services Task Force strongly recommends that clinicians routinely screen all sexually active women aged 25 years and younger, and other asymptomatic women at increased risk for infection, for chlamydial infection. (see â œClinical Considerationsâ below for discussion of risk factors). A recommendation

The US Preventive Services Task Force found good evidence that screening women at risk for chlamydial infection reduces the incidence of pelvic inflammatory disease and fair evidence that community-based screening reduces prevalence of chlamydial infection. The US Preventive Services Task Force concludes that the benefits of screening substantially outweigh the potential harms (see â Potential Adverse Effects of Screeningâ in the "Potential Harms" field).

- The US Preventive Services Task Force makes no recommendation for or against routinely screening asymptomatic low-risk women in the general population for chlamydial infection. C recommendation

The US Preventive Services Task Force found at least fair evidence that screening low-risk women could detect some additional cases of Chlamydia trachomatis, but concludes that the potential benefits of screening low-risk women may be small and may not justify the possible harms.

- The US Preventive Services Task Force recommends that clinicians routinely screen asymptomatic pregnant women aged 25 years and younger and others at increased risk for infection for chlamydial infection (see â œClinical

Considerationsâ below for discussion of risk factors in pregnancy). B recommendation

The US Preventive Services Task Force found at least fair evidence that screening and treatment of women at risk for chlamydial infection improves pregnancy outcomes and concludes that the benefits of screening outweigh potential harms.

- The US Preventive Services Task Force makes no recommendation for or against routine screening of asymptomatic, low-risk pregnant women aged 26 years and older for chlamydial infection. C recommendation.

The US Preventive Services Task Force found fair evidence that the benefits of screening low-risk pregnant women are small and may not justify the possible harms.

- The US Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against routinely screening asymptomatic men for chlamydial infection. I recommendation.

No direct evidence was found to determine whether screening asymptomatic men for chlamydial infection is effective for reducing the incidence of new infections in women. The benefits and harms of screening men cannot be determined, but the potential magnitude of benefits could be large if the effectiveness of screening men can be demonstrated.

Clinical Considerations

- Women and adolescents through age 20 years are at highest risk for chlamydial infection, but most reported data indicate that infection is prevalent among women aged 20 to 25.
  Age is the most important risk marker. Other patient characteristics associated with a higher prevalence of infection include being unmarried, African-American race, having a prior history of sexually transmitted disease, having new or multiple sex partners, having had cervical ectopy, and using barrier contraceptives inconsistently. Individual risk depends on the number of risk markers and local prevalence of the disease. Specific risk-based screening protocols need to be tested at the local level.
- Clinicians should consider the characteristics of the communities they serve in determining appropriate screening strategies for their patient population.
  More targeted screening may be indicated in specific settings as better prevalence data become available. Prevalence of chlamydial infection varies widely among communities and patient populations. Knowledge of the patient population is the best guide to developing a screening strategy. Local public health authorities can be a source of valuable information.
- The optimal interval for screening is uncertain.
  For women with a previous negative screening test, the interval for re-screening should take into account changes in sexual partners. If there is evidence that a woman is at low risk for infection (e.g., in a mutually monogamous relationship with a previous history of negative screening tests for chlamydial infection), it may not be necessary to screen frequently. Re-

screening at 6-12 months may be appropriate for previously infected women because of high rates of reinfection.

- The optimal timing of screening in pregnancy is also uncertain.
  Screening early in pregnancy provides greater opportunities to improve pregnancy outcomes, including low birth weight and premature delivery; however, screening in the third trimester may be more effective at preventing transmission of chlamydial infection to the infant during birth. The incremental benefit of repeated screening is unknown.
- Screening high-risk young men is a clinical option.
  Until the advent of urine-based screening tests, routine screening of men was rarely performed. As a result, very little evidence regarding the efficacy of screening in men in reducing infection among women exists. Trials are underway to assess the effectiveness of screening asymptomatic men. The choice of specific screening technique is left to clinical judgment.

  Choice of test will depend on issues of cost, convenience, and feasibility, which may vary in different settings. Although specificity is high with most approved tests, false-positive results can occur with all non-culture tests and rarely with culture tests. The CDC is developing laboratory guidelines that outline the advantages and disadvantages of available tests. These guidelines will be available at the CDC's Web site in 2001.

- Partners of infected individuals should be tested and treated if infected or treated presumptively.
- Clinicians should remain alert for findings suggestive of chlamydial infection during pelvic examination of asymptomatic women (e.g., discharge, cervical erythema, and cervical friability).
- Clinicians should be sensitive to the potential impact of diagnosing a sexually transmitted disease on a couple.
  To prevent false-positive results, confirmatory testing may be appropriate in settings with low population prevalence.

<u>Definitions:</u>

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

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D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

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Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Early Detection

The strongest evidence supporting screening is a well-designed randomized trial demonstrating that screening women at risk (prevalence of infection 7%) reduced the incidence of pelvic inflammatory disease from 28 per 1000 woman-years to 13 per 1000 woman-years. The prevalence of chlamydial infection has declined in populations that have been targeted by screening programs (primarily women attending family planning and other publicly funded clinics). In addition, two ecological analyses in Europe reported reductions in ectopic pregnancy and pelvic inflammatory disease with the advent of community-based screening for chlamydial infection. There is little evidence of the effectiveness of screening asymptomatic women who are not in high-risk groups.

There is fair evidence indicating that screening for chlamydial infection among asymptomatic high-risk pregnant women and subsequent treatment improves pregnancy outcomes. Two non-randomized trial studies demonstrated improved pregnancy outcomes following treatment of chlamydial infection: less premature rupture of membranes, less low birth weight, higher infant survival, and fewer small-for-gestational age births. There is little evidence regarding the effectiveness of screening and treatment of asymptomatic pregnant women who are not in high-risk groups.

There is good evidence showing that treatment of men can eradicate chlamydial infection. Unfortunately, there are no studies describing the effectiveness of screening or early treatment of men in reducing acute infection and sequelae in men or women.

POTENTIAL HARMS

Potential Adverse Effects of Screening

No studies were identified that directly examined adverse effects of screening. Potential harms include adverse effects of both false-positive and true-positive diagnoses of a sexually transmitted disease on patients and their partners, the inconvenience of pelvic examinations for tests employing cervical specimens, and the potential harms of adverse reactions from antibiotic treatment. There may be added cost for confirmation of positive results and testing of partners.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The USPSTF identified 8 cost-effectiveness or cost-benefit analyses that examined screening in non-pregnant and pregnant women. These analyses suggest that screening may be cost-saving when conducted among nonpregnant women who are at moderate to high risk of chlamydial infection. These studies also suggest that selective screening is more likely to be cost-effective than universal screening, and that less expensive and more sensitive DNA or RNA tests would improve cost-effectiveness when compared with culture. However, because of inconsistencies in methodology and assumptions made in these cost analyses, the USPSTF concludes that available evidence on cost-effectiveness is insufficient to guide specific screening recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force (USPSTF) equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force (USPSTF) reports. The U.S. Preventive Services Task Force (USPSTF) convened representatives from the various audiences for the Guide - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force (USPSTF) and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force (USPSTF) materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force (USPSTF) products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

- Screening for Chlamydial Infection. What's New from the Third USPSTF.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for chlamydial infection. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):90-4. [7 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2001 Apr)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

The U.S. Preventive Services Task Force (USPSTF) consists of 13 experts from the specialties of family medicine, pediatrics, internal medicine, obstetrics and gynecology, geriatrics, preventive medicine, public health, behavioral medicine, and nursing. Members of the Task Force were selected from more than 80 nominees, based on recognized expertise in prevention, evidence-based medicine, and primary care.

Names of members: Alfred O. Berg, MD, MPH (Chair); Janet D. Alan, PhD, RN, CS, FAAN (Vice-Chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; Carole Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J Pender, PhD, RN, FAAN; Harold C Sox, Jr., MD; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H Woolf, MD, MPH

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for chlamydial infection—including ocular prophylaxis in newborns. In: Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996.

GUIDELINE AVAILABILITY

Electronic copies: Available from AJPM (American Journal of Preventive Medicine) Online. Additional information is available from the U.S. Preventive Services Task Force (USPSTF) Web site and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Nelson HD, Helfand M. Screening for chlamydial infection. Am J Prev Med 2001 Apr;20(3S):95-107. [133 references]
- Screening for chlamydial infection. Rockville (MD): Agency for Healthcare Research and Quality, 2001. (Systematic evidence review; no. 1) [146 references] (Electronic copies are only available in a downloadable format from the USPSTF Web site.)

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.

- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from the USPSTF Web site.

Additional Implementation Tools:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

  Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

- The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.
- Screening for chlamydial infection. What's new from the third USPSTF. Rockville (MD): Agency for Healthcare Research and Quality; 2001 Mar. Electronic copies: Available from USPSTF Web site.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

NGC STATUS

This summary was completed by ECRI on April 6, 2001. The information was verified by the guideline developer as of April 10, 2001.

COPYRIGHT STATEMENT

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Date Modified: 11/15/2004